Washington Health Care Authority

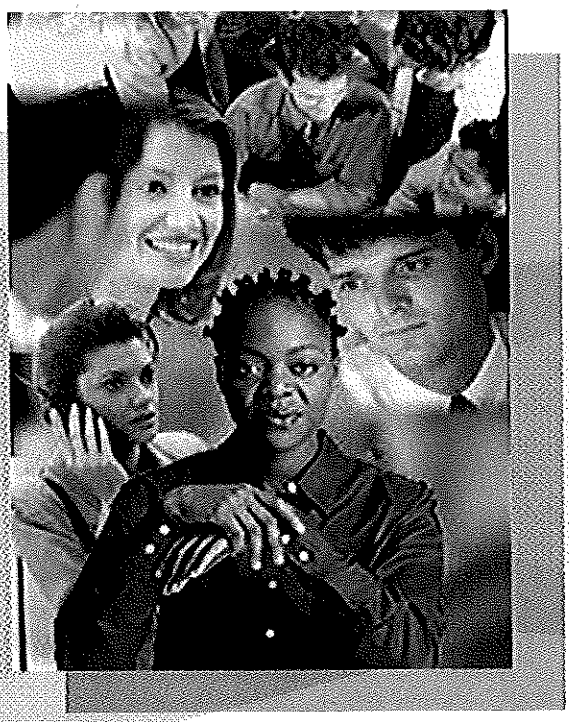
Department of Social & Health Services

Washington State Transitional Bridge Demonstration

Section 1115 Quarterly Report

Demonstration Year 1: 1/1/11 – 12/31/11

Federal Fiscal Quarter 2-3: 1/1/11 – 6/30/11



2011 - 2013

STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

July 14, 2011

Cindy Mann, Director
Center for Medicaid and State Operations
Centers for Medicare and Medicaid Services
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Baltimore, Maryland 21244-1850

Dear Ms. Mann:

Washington State's Transitional Bridge 1115 waiver was approved and became effective in January 2011. Immediately after, the state encountered one of the most difficult legislative sessions in history, which included a second special legislative session to deal with the state fiscal year 2011 budget shortfall and to negotiate the final 2011-13 biennial budget. There is little question that, without the waiver, Transitional Bridge programs would have been eliminated earlier this year. While they did not come through the legislative debate unscathed, they have been funded for the next biennium to provide coverage to about 60,000 individuals who would otherwise be uninsured. That is testament to the value of our partnership with the Centers for Medicare and Medicaid Services (CMS) and to the diligent efforts of CMS staff who continue to provide technical assistance through our ongoing implementation milestones.

This report, the first official quarterly report on the Transitional Bridge, documents progress in implementing the demonstration with particular attention to the status of expected milestones, the broad impact of legislative action, and operational timing and constraints. There have been many difficult challenges and, unfortunately, a few unavoidable delays, which have been discussed in regular and frequent interactions with CMS staff, and are included in the report to provide assurance that progress does steadily continue. Now that the state's legislative budgets are set, staff can focus on stabilizing the programs for what is hopefully the duration of the demonstration.

In addition to the obvious continuation of coverage, the Transitional Bridge is providing an opportunity to uncover administrative and technical issues that must be addressed to ensure a seamless transition to national health reform and the full Medicaid expansion in 2014. Through ongoing administrative planning and cost containment strategies, staff continues to create efficiencies, meet budget demands, and retain benefits and services for clients. Continuation of the demonstration is clearly critical to Washington State, and we look forward to an ongoing successful partnership with CMS.

Per our current Special Terms and Conditions agreement, Jenny Hamilton, Program Manager will continue to serve as the point of contact for questions on the demonstration. She can be reached at (360) 725-1101 or via email at jenny.hamilton@dshs.wa.gov.

Sincerely,

Doug Porter
Director

cc: Jenny Hamilton, Program Manager, HCP, HCA

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A. Demonstration Description:

Through the early Medicaid expansion option provided in the Patient Protection and Affordability Act (ACA) Section 1902(k)(2), Washington's Transitional Bridge Demonstration waiver sought approval for Medicaid (Title XIX) matching dollars to help sustain the Basic Health and Medical Care Services (Disability Lifeline and ADATSA) programs until national health reform is fully implemented in 2014. These programs had previously been fully state-funded and as a result of the severe fiscal crisis in Washington state they were eliminated in the Governor's recent proposed supplemental and biennial budgets.

Approval of the 1115 Demonstration allows Washington to support the following goals:

- Continue coverage for low-income individuals enrolled in the Basic Health and Medical Care Services (Disability Lifeline and ADATSA) programs until the full expansion of the Medicaid program takes effect in 2014. (*At that time, individuals with family incomes up to 133 percent of the FPL will be covered under the Medicaid State plan. Currently these individuals are under age 65, not-pregnant, and not otherwise eligible for Medicaid and Supplement Security Income.*)

- Use the Transitional Bridge programs as a dynamic early-learning laboratory to (a) identify and resolve issues that many states may face in preparing to implement the ACA Medicaid expansion in 2014, and (b) inform federal and state policy makers about program attributes that are consistent with ACA policy goals and provisions and could be considered for new Medicaid expansion and currently Medicaid-eligible populations.

B. State Contacts:

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C. Demonstration Progress:

This report provides a comprehensive record of progress on the Transitional Bridge Demonstration for the period January 1, 2011 – June 30, 2011, including the status of milestones, enrollment, the impacts of legislative action, operational challenges and lessons learned, and an overview of budget neutrality. For the most part it summarizes regular CMS monitoring calls, with technical assistance requests and implementation issues noted where applicable.

Although this report was delayed by the uncertainty and constraints imposed by 2011 Legislative action, we expect to be back on track to meet future progress reporting requirements. The next quarterly progress report is due August 31, 2011.

1. Milestone Expectations

The Transitional Bridge Demonstration was approved and became effective January 2011 with an expectation that it would be a dynamic transition towards national health reform in 2014. Periodic milestones occur over the course of the demonstration and have been included as explicit requirements of the Special Terms and Conditions. Milestones are listed below with a brief description of their current status. Those completed are shaded.

MILESTONES	STATUS
2011:	
Citizenship determination based on data matching through the social security verification system.	Process was tested and successfully applied to verify citizenship for existing Basic Health enrollees - see section 4, Operational Challenges regarding additional data match contract requirements that apply to automating the process for new applicants going forward.
Elimination of MCS time limits (i.e., maximum eligibility period of 24 months in a 5 year period).	Completed. Although implemented prior to Transitional Bridge approval, time limits were reversed in response to litigation and to meet CMS' STCs. Authorized through SHB 1312 - see section 3, Legislative Action.
Screening of new BH applicants and enrolled BH members (during recertification) for Medicaid eligibility and enrollment.	Implemented. Required to support HB 1544 and authorized through SHB 1312 - see section 3, Legislative Action.
Income determination for identification of BH and MCS individuals eligible for federal match claim based on the Family Medicaid (TANF) methodology as allowed in the CMS guidance letter of April 9, 2010.	Implemented. This is key to determination of Transition Eligible status.
Rollback of monthly premium cost sharing to 2009 levels for the lowest income BH enrollees (i.e., individuals with family income from 0-65 percent of the FPL)	Implemented. Effective 1/1/11 premium contributions for Basic Health enrollees in income band A reduced from $34 to $17 for the duration of the demonstration.
Exemption of American Indian/Alaska Natives from premium and point-of-service cost sharing in Basic Health.	As required in the STCs, this will be retro-active to 1/1/11 as soon as the revised Basic Health managed care contract is signed. See section 4, Operational Challenges regarding Transitional Bridge managed care contract updates.
Equitable approach to managing the Basic Health waiting list given priority designation of sponsored AI/ANs and potential impact of eliminating Tribal cost sharing.	

MILESTONES	STATUS
Mental health parity for Basic Health.	Statutory and regulatory changes completed
No cost sharing for preventive care.	Implemented 1/1/11
Elimination of pre-existing condition waiting period for BH children (limited numbers).	Implemented 1/1/11
No reduction in Basic Health benefits; MCS benefits changes tied only to changes in the State Plan.	No change in Basic Health benefits. State Plan amendments (SPA) directed by 2EHB 1087 require MCS benefits revisions to match. A SPA is currently being developed – see section 3, Legislative Action.
Fair hearings for Basic Health (denials of service) processed through Medicaid systems once the formal Independent Review Organization (IRO) process is exhausted.	STC milestone 7/1/11 – a requirement established in the revised Basic Health managed care contract with signature requested by July 19, 2011. See section 4, Operational Challenges regarding Transitional Bridge managed care contract updates. Internal process changes are being further revised/streamlined as a component of the merger of the Health Care Authority (HCA) and the Medicaid Purchasing Administration – see section 3, Legislative Action, 2E2SHB 1738.
Systems and processes in place to claim for federal match	Operational for Medical Care Services – Disability Lifeline and ADATSA demonstration groups. Systems and procedures for the Basic Health program are ready, but claiming has been delayed until the revised Basic Health contract is signed so that payment adjustments to support STCs related to AI/AN exemption from cost sharing are included. See section 4, Operational Challenges regarding Transitional Bridge managed care contract updates.
Administrative and information system challenges and enhancements identified (if any) to: • track out-of-pocket charges and determine 5% aggregate cost sharing cap for low income population coverage options in 2014; • ensure that no federal financing support is claimed for services provided in Institutions for Mental Disease (IMDs) – currently this is approximately 2% of expenditures for the MCS program, 0% for BH; and • allow a smooth interface among coverage options that support low income populations. Manual administrative controls may initially be necessary, with automated processes developed over time to meet PPACA compliance in 2014.	Anticipated as a component of cost-sharing discussions related to the proposal submitted to CMMI by Governor Gregoire (April 29, 2011) for the authority to implement "Health Innovations for Washington". Will be incorporated in end of year processing by the HCA's actuarial consultant. Tested during development of the waiver application. Administrative processes continually being enhanced for transitions between Basic Health and Medicaid programs.
2012:	
Competitive purchasing efficiencies including joint BH/Medicaid procurement (with standardized quality and performance measures,	2012 managed care contract procurement in progress - draft request for proposal (RFP) and accompanying contract released for comment. Revisions and further analysis currently

MILESTONES	STATUS
application streamlining, common Basic Health/Medicaid managed care delivery system) and delivery system streamlining to fully support mental health parity for all MCS enrollees.	suggest a formal release mid-summer for implementation July 2012.
Methodology implemented for determining and capturing demographic data to identify American Indian/Alaskan Native (AI/AN) tribal membership. This will inform the potential interface requirements among coverage options for low income populations in 2014 to support cost sharing restrictions for AI/AN individuals.	As of 6/30/11, there are 870 Tribal members enrolled in Basic Health through 11 Sponsorship Tribes. Under their agreement with the HCA, Tribal Sponsors are required to obtain and maintain documentation of eligible native status for individuals they sponsor. Exemption from cost-sharing will be retro-active to 1/1/11, a requirement established in the revised Basic Health managed care contract with signature requested by July 19, 2011. See section 4, Operational Challenges regarding Transitional Bridge managed care contract updates. Additionally the HCA is working through the American Indian Health Commission to develop processes for the identification of other eligible American Indian/Alaska Native populations. *Preliminary* documentation requirements being discussed are included as Appendix A. Further CMS technical assistance has been requested to approve the approach before it can be implemented.
Elimination of pre-existing condition waiting period for BH adults.	For future discussion of the 2012 Basic Health managed care contract.
2013:	
Modified adjusted gross income (MAGI) calculation for Basic Health program eligibility (assuming details known) as an opportunity to work out any administrative challenges prior to PPACA compliance in 2014.	Staff is engaged with CMS in ongoing discussions of ACA impact on eligibility.
Cost sharing evaluation findings (and implications) available.	See preliminary Evaluation Plan below.
Systems expansion to accommodate federal match and adopt encounter rate payments for services provided in Tribal facilities for AI/ANs covered under capitated contracts.	For further discussion based on implementation of methodology for identifying and tracking AI/AN status. Preliminary conversations to raise awareness and understand potential timing of systems changes have been initiated.
2014:	
Prepared to adopt PPACA requirements for Medicaid.	For future discussion.
Single contract (to be considered if state Basic Health option offers best continuity of coverage/cliff avoidance for 133-200% FPL individuals).	

2. Enrollment

For the period 1/1/11 – 6/30/11, average caseloads and Transition Eligible enrollment in the Basic Health and Medical Care Services (Disability Lifeline and ADATSA) programs are summarized in the following table. Monthly rolling counts for actual and projected enrollment are included with section 5 details on budget neutrality.

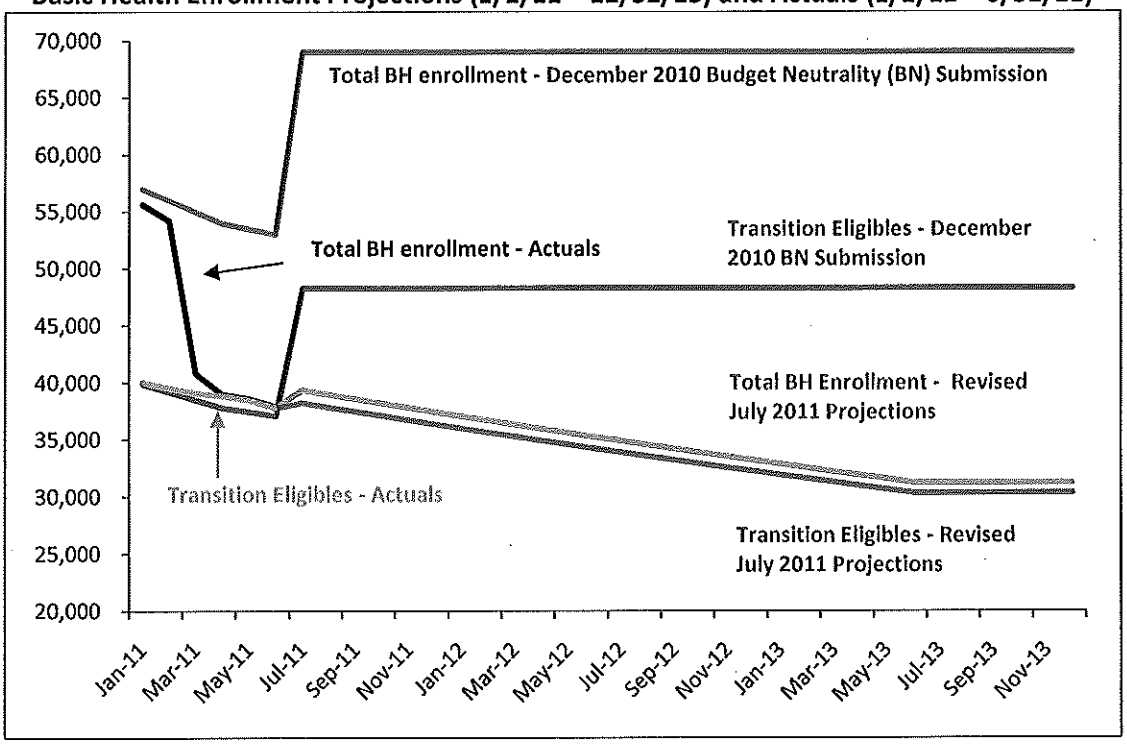
Demonstration Group	STC Annual Average Transition Eligibles	Quarterly Average Program Caseload	Quarterly Average Transition Eligibles
Basic Health	43,300	Q1 (1/1/11 – 3/31/11) 50,197 Q2 (4/1/11 – 6/30/11) 38,476	Q1 (1/1/11 – 3/31/11) 39,555 Q2 (4/1/11 – 6/30/11) 38,352
Medical Care Services (Disability Lifeline)	16,000	Q1 (1/1/11 – 3/31/11) 18,378 Q2 (4/1/11 – 6/30/11) 18,117	Q1 (1/1/11 – 3/31/11) 17.990 Q2 (4/1/11 – 6/30/11) 17,759
Medical Care Services (ADATSA)	4,000	Q1 (1/1/11 – 3/31/11) 4,215 Q2 (4/1/11 – 6/30/11) 4,127	Q1 (1/1/11 – 3/31/11) 4,212 Q2 (4/1/11 – 6/30/11) 4,122

Demonstration Group Overview:
The following describes the current status of enrollment for each demonstration group, with references to interventions that impacted enrollment since implementation of the Transitional Bridge demonstration. For clarification, a short summary is provided at the end of this section.

Demonstration Group – Basic Health:
Enrollment projections used in the development of STCs were based on budget assumptions for BH that changed over the course of implementing the Transitional Bridge Demonstration. As a result of Legislative action and the required gathering of social security numbers (SSN) to determine Transition Eligible status, the demographic details of BH enrollment changed considerably between December 2010 and June 2011.

- The original basis for BH enrollment projections was the state fiscal year (SFY) 2010 supplemental budget executed May 5, 2010. It assumed that Washington would be successful in obtaining the Transitional Bridge demonstration waiver with allowance for federal financial participation (FFP) to sustain the program at an enrollment maximum of 69,000 by June 2011.
- The 2011 early action supplemental budget (HB 3225) assumed that BH enrollment would be managed through the remainder of SFY 2011 with a decline in subsidized enrollment to 52,000 by June 2011.
- The second 2011 supplemental budget (ESHB 1086) restricted BH enrollment to Transition Eligibles (TE) with the assumption that coverage for non-TEs would be terminated. (Details of the ensuing disenrollment are provided in section 4, Operational Challenges.
- The 2011-13 biennial budget (2ESHB 1087) continues to limit BH enrollment to Transition Eligibles and assumes a 1 percent attrition rate. Enrollment is expected to average approximately 37,000 enrollees per month during SFY 2012 and 33,000 per month during SFY 2013. New applicants from priority populations were not excluded from enrollment – the primarily include sponsored AI/ANs and individuals who are returning to BH after losing traditional Medicaid eligibility.

Basic Health Enrollment Projections (1/1/11 – 12/31/13) and Actuals (1/1/11 – 6/31/11)



- **Distribution of Basic Health by Age** (see chart in Appendix B)
  Given that social security identification has historically not been required from BH applicants, original STC projections of BH Transition Eligibles reflected an assessment of citizenship for parents enrolled in the program. Without reason to assume otherwise, we did not expect the age and income distribution of the remaining single adult population to change.
  After implementation of the Transitional Bridge, BH enrollees for whom there was no SSN on file were asked to provide details to support Washington's compliance with STCs[1]. The *required* collection of SSNs following Legislative action that limited eligibility for BH to just Transition Eligibles has resulted in a **shift in the age distribution of the program.** Between July and December 2010 the proportion of BH enrollment over age 40 remained at about 55%. By June 2011 that had increased to 63%. The redistribution from the younger age bands A and B, to older age bands C and D (where state subsidies are higher), can be seen in the following table. Individuals in Age band E, age 65 plus, were disenrolled.

- **Distribution of Basic Health by Income** (see chart in Appendix B)
  Minor shifts towards the lower income bands occurred as can also be seen in the following table.

[1] Individuals determined eligible for Medicaid must be transitioned to Medicaid coverage. This could not be fully implemented without SSN data to assess immigration status.

Change in BH Enrollment by Age and Income Bands: December 2011 – June 2011

Income Band	Age Band					
	A 0-25	B 0-39	C 40-54	D 55-64	E 65+	Total
A	-0.40%	-1.50%	1.13%	1.92%	-1.13%	**0.02%**
B	-0.24%	-2.19%	0.94%	1.67%	-0.07%	**0.10%**
C	-0.23%	-1.62%	0.62%	1.21%	-0.03%	**-0.05%**
D	-0.14%	-0.51%	0.35%	0.25%	-0.01%	**-0.06%**
E	-0.07%	-0.34%	0.25%	-0.02%	-0.01%	**-0.19%**
F	-0.10%	-0.06%	0.16%	-0.07%	0.00%	**-0.08%**
G	-0.01%	0.04%	0.23%	-0.13%	0.00%	**0.13%**
H	-0.03%	0.05%	0.15%	-0.10%	0.00%	**0.06%**
I	0.00%	0.02%	0.02%	0.02%	0.00%	**0.05%**
J	0.00%	0.00%	0.01%	0.01%	0.00%	**0.02%**
Total	**-1.20%**	**-6.12%**	**3.84%**	**4.74%**	**-1.27%**	

- **Distribution of Basic Health by County** (see table in Appendix B)
  Disenrollment of non-Transition Eligibles described further in section 4, Legislative action and section 5, Operational Challenges, resulted in a **shift in the distribution of the program** across counties, with enrollment now more concentrated in the more expensive counties. The most significant decreases occurred in two relatively less expensive counties, King and Yakima.

- **Enrollment by Tribal Sponsorship**
  Change in Tribal sponsorship was relatively unaffected, but as a proportion of total BH enrollment, individuals determined to be American Indian/Alaskan Native now make up a larger portion of enrollment than anticipated. That change is marked by dashed in the table below, and shown in the chart in Appendix B.

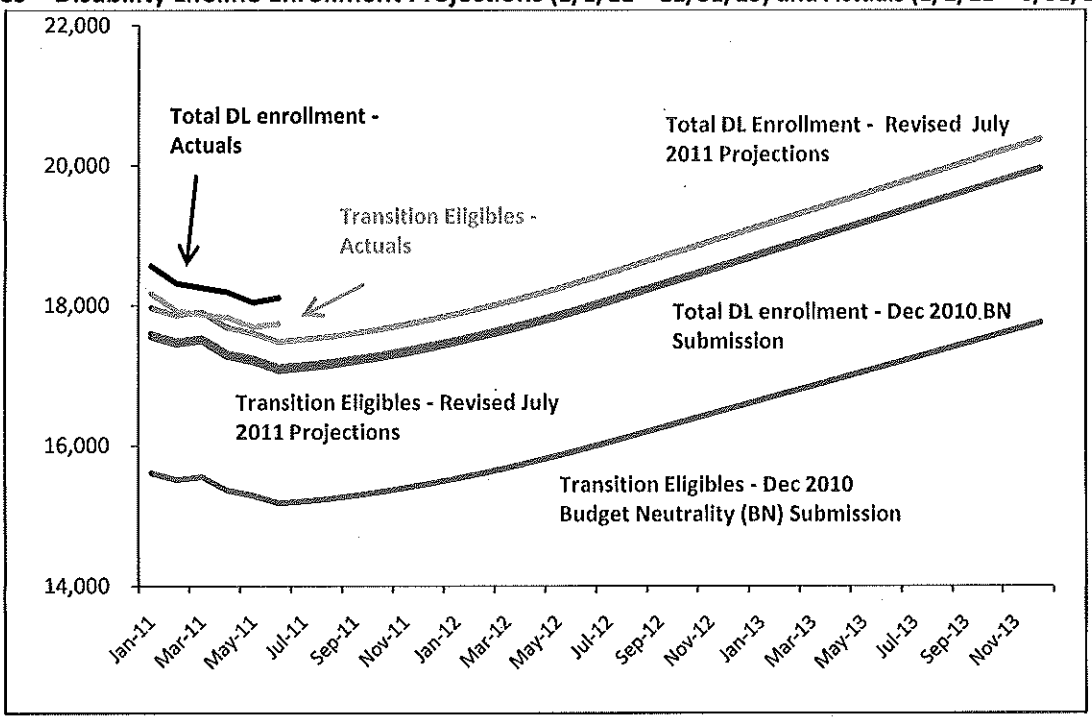
Tribal Enrollment in BH: July 2010 – June 2011

Month of Coverage	Total BH Enrollment	Tribal Enrollment	Percent of Total BH Enrollment
Jul-10	64,105	**889**	1.4%
Aug-10	62,520	**901**	1.4%
Sep-10	60,993	**880**	1.4%
Oct-10	59,542	**891**	1.5%
Nov-10	57,966	**902**	1.6%
Dec-10	56,394	**911**	1.6%
Jan-11	55,614	**931**	1.7%
Feb-11	54,181	**920**	1.7%
Mar-11 (TE Pop only)	40,797	**906**	2.2%
Apr-11	38,824	**850**	2.2%
May-11	38,475	**888**	2.3%
Jun-11	37,873	**870**	2.3%

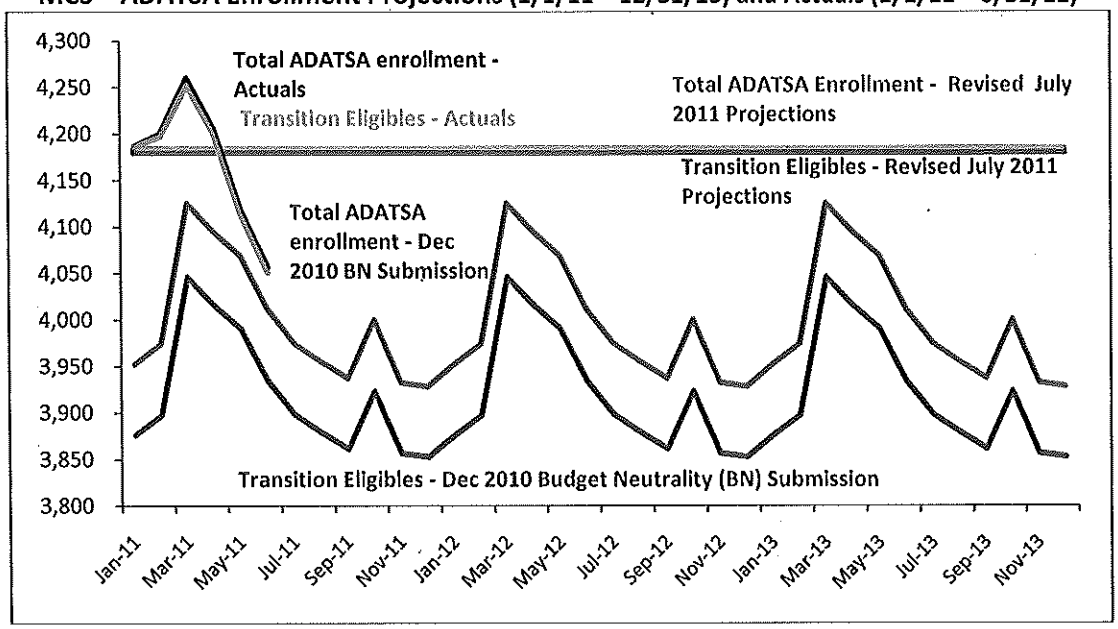
Demonstration Group – Medical Care Services – Disability Lifeline and ADATSA:

Enrollment projections used in the development of STCs were based on November caseload data. Actual caseload has been tracking higher than originally projected. In addition, the assessment of immigration status was considerably understated – for the first 6 months of the Transitional Bridge, about 98% of the Disability Lifeline population had confirmed immigration status (using the Social Security Administration electronic match) as Transition Eligibles, about 9% more than originally estimated.

MCS – Disability Lifeline Enrollment Projections (1/1/11 – 12/31/13) and Actuals (1/1/11 – 6/31/11)



MCS – ADATSA Enrollment Projections (1/1/11 – 12/31/13) and Actuals (1/1/11 – 6/31/11)



Enrollment Summary:

As described above, enrollment in the Basic Health program changed considerably from the population on which our original Transitional Bridge application was based. In addition to a smaller membership than anticipated (to meet budget appropriations), demographic shifts occurred in response to legislative action. These include changes in:

- The age distribution - towards an older (and therefore more costly) membership
- The income distribution – (slightly) towards a lower income membership, for whom subsidies are highest
- The geographic distribution – membership is more concentrated in higher cost counties as a result of disproportionate disenrollment for relatively lower cost counties, King and Yakima in particular.

Analysis of the impact of these demographic shifts on budget calculations and 2012 joint procurement activities is preliminary, but our real experience indicates that our original assumptions were for a very different base. This is referenced further in section 5, Budget Neutrality.

For the Medical Care Services (Disability Lifeline and ADATSA) programs, enrollment is slightly higher than original projections suggested.

Impact of these enrollment shifts will need to be discussed further with CMS.

3. Legislative Action

The 2011 Legislative session began January 10, 2011 and ended April 22, 2011. A subsequent Special Session was called by Governor Gregoire to finalize the 2011-2013 Biennial budget. This special session began April 26, 2011 and ended May 25, 2011; the Biennial budget was enacted 6/15/11, effective 7/1/11. A full set of current and historical budget documents is available at: http://leap.leg.wa.gov/leap/budget/index_lbns.asp.

The following table summarizes statutory provisions and their impact on Transitional Bridge programs, as discussed with CMS during the June 21, 2011 monitoring call. Further discussions are being planned where Legislative action will require technical correction and possible amendments to current STCs.

Enacted Statute and Implementation Challenges	Impact on Transitional Bridge Demonstration Programs
SHB 1312 – authorized implementation of program changes required by Special Terms and Conditions (STC)	• Individuals may not choose to stay in Basic Health if they are otherwise eligible for Medicaid coverage • Collection of social security numbers required (i.e., no longer voluntary) to support efficient Transitional Bridge eligibility determination • Wait list for Medical Care Services allowed if it appears that caseload might exceed appropriated funding • Medical Care Services enrollees must be grandfathered into continued coverage if legislated changes in eligibility would otherwise result in termination of their coverage
HB 1544 – restricted enrollment of Basic Health program to Transition Eligible population as of 3/1/11 with assumption of appropriation to match	• 1,572 children disenrolled from Basic Health and enrolled in the Apple Health for Kids program. 16,989 members disenrolled from Basic Health due to: immigration status, age 64+, or countable income greater than 133% FPL. By 4/11/11 7,398 appeals resulted in 4,188 reinstatements retroactive to 3/1/11. • Resources diverted to manage multiple member communications regarding program eligibility/potential termination and social security number collection • Prolonged difficult disenrollment, appeals, reinstatement period, including pending litigation - a lawsuit has been filed in federal district court challenging the disenrollment of Basic Health enrollees who did not meet transition eligibility. Although the lawsuit may affect the Basic Health program, it does not affect Transition Eligibles. For reference, the lawsuit is Unthanksikun v. Douglas Porter, et al. No. 2:11-cv-00588, US District Court, Western District of Washington at Seattle. • Less immediate waiver implementation details took lower priority • Enrollment declined from ~56,000 in January to ~38,000 by June 2011. Changes in membership demographics are described in section 2, Enrollment.

Enacted Statute and Implementation Challenges	Impact on Transitional Bridge Demonstration Programs
E2HB 2082 – eliminated Disability Lifeline program 10/31/11 and replaced it with 3 new programs effective 11/1/11 • Medical Care Services-Essential Needs and Housing Supports (*TB demonstration population*) • Pregnant Women's Assistance Program • Aged, Blind and Disabled Assistance Program	• Previous Disability Lifeline demonstration populations continue to receive coverage through Medical Care Services • Discussions in progress to determine process, questions that may require CMS technical assistance, and satisfy STC 90-day approval requirement assuming wait list may be required – systems' changes will be substantial • Confirms that eligibility (income/resources) remain at the level prior to Transitional Bridge approval (i.e., the grandfathering requirement authorized in SHB 1312)
ESHB 1086 (final supplemental budget for FY2010) – established Basic Health appropriation based on restricted enrollment per HB1544	• Established funding consistent (retroactive) with expectations directed by HB 1544: – As of 3/1/11 enrollment in Basic Health restricted to Transitional Bridge (TB) eligibles – Children not TB-eligible transferred to the Apple Health for Kids program (system changes and communications did not allow this to occur until 4/1/11) • Medical Care Services funded to support caseload forecast.
2EHB 1087 (FY11-13 biennial budget) – prescribed funding and programmatic changes related to: • Benefit changes consistent with Medicaid program • Program funding and caseload limits • Personnel reductions • Agency consolidation	• Frequent resource diversion to conduct analysis to inform debate over many different versions of bills affecting Transitional Bridge programs • Medical assistance program optional benefits change as of 7/1/11 – Maximum of 3 emergency room visits for a non-emergent condition per enrollee per year. Hospitals may directly bill enrollees for 4th and subsequent visits for non-emergent conditions such as ear infections, colds, sore throats, sinusitis, dermatitis, sunburn, migraines and other headaches, joint or back pain. – Adult hearing aids and devices, and eyeglasses not covered – Occupational, physical, and communication disorder therapies restricted to 12 visits per year for adults with injuries to the brain, hips, knees, or spine and to 6 visits per year for persons with all other injuries. – Only emergency dental will be covered in Medical Care Services (NOTE: Dental coverage continues for children, individuals with developmental disabilities, and elderly in nursing homes and receiving community-based waiver services). • Basic Health enrollment reduction to be achieved by attrition – TB funded at level expected to sustain average enrollment of approximately 37,000 in SFY2012 and 33,000 in SFY2013.
2E2SHB 1738 – changed designation of Medicaid state agency	• Effective 7/1/11 the Health Care Authority (HCA) combines and coordinates the functions of Washington's major medical assistance programs for low-income and disabled residents who qualify under state and federal standards, and provides health care benefits for Washington State employees, retirees and their dependents. The Medicaid single state agency is transferred from the Department of Social and Health Services (DSHS) to the HCA.

4. Operational Challenges and Lessons Learned

Implementing the Transitional Bridge at the same time as we navigated a difficult Legislative session and continuing economic crisis has been a huge operational challenge. Limited resources faced a need to refine complex systems changes and processes while simultaneously weighing the implications of varying Legislative options for meeting budget constraints and STC requirements. With a hiring freeze and furloughs in place, the timing of business activities to respond to Legislative action left little room for desired stakeholdering and resulted in unavoidable delay of Transitional Bridge milestone deliverables, including revised managed care contracts (described further below) and this first quarterly report, which was delayed until Legislative action was complete and the operational environment stable enough to report on. Operational challenges and lessons learned are described below.

Lessons Learned

- The need to have federal approval *before* the 2011 Legislative session began was assumed to be critical and (virtually) daily interactions between CMS and Washington state occurred in December 2010 to allow that to happen. Without official approval of the Transitional Bridge, fiscal information would not have been available for Legislative action to sustain the Basic Health and/or Medical Care Services programs - at any level.

- As approval of Special Terms and Conditions (STCs) came down to the January 2011 "go live" target, we continued STC refinements *in parallel* with CMS' "readiness review" and systems development. Because the Basic Health, Disability Lifeline and ADATSA programs had been successfully operating for many years we were able to conduct comprehensive presentations of operational processes to demonstrate their readiness for the Transitional Bridge demonstration. This was an efficient approach to support implementation the moment approval was granted.

- The value of establishing the Transitional Bridge waiver as a *dynamic* demonstration is undeniable. It provided flexibility for Washington to make steady progress in spite of the changing fiscal context, implement as soon as waiver approval was received, and schedule milestone revisions to address additional CMS requirements throughout the life of the Demonstration. Coverage therefore continues for Transition Eligibles while administrative processes are streamlined, health plans are informed of upcoming contractual expectations, and stakeholders engage in status reporting.

- For several months after implementation, we found it most helpful to schedule *weekly check-ins with CMS* as an opportunity to review questions, issues, technical assistance needs, and ensure progress continued as expected. Stakeholders were also engaged in bi-weekly status discussions. Keeping implementation challenges transparent, especially during Legislative session, was essential to staying on track. Ongoing interactions are being scheduled.

Operational Challenges

Over the first few months the interplay of consistent themes – resource constraints, future fiscal uncertainty and the timing of Legislative action – resulted in several operational challenges including:

- Disability Lifeline grandfathering
- Managed Care contract revisions needed to support STCs
- Basic Health social security interface
- Termination from Basic Health of non-Transition Eligibles
- Disability Lifeline Replacement, wait list and outreach.

Disability Lifeline Enrollee Grandfathering:
Based on a Special Session in December 2010, grant payments were reduced to recipients of Disability Lifeline (DL) assistance on 1/1/11, in order to maintain expenditures within the amount appropriated in the state's operating budget. The typical monthly grant for a single person was reduced from $339 to $266. To be consistent with Transitional Bridge STCs, an eligibility system workaround was developed to ensure that Medical Care Services (MCS) coverage was maintained for DL clients whose income was between $266 and $339. A further grant reduction from $266 to $197 per month occurred on 4/1/11 in response to lower than anticipated State revenues. The eligibility system workaround continued to allow MCS coverage to be grandfathered for clients who lose eligibility for cash assistance but whose income is not greater than the level approved in the Transitional Bridge STCs (i.e., $339).

Managed Care Contract Revisions:
STCs anticipated that the existing managed care contract for the Basic Health program would require minor revisions for CMS approval and would be in place 4/1/2011, with language adopted from the approved Medicaid Healthy Options contract wherever possible. The MCS-DL contract had been undergoing a BBA compliance review and was expected to need further revision as a result of legislative action. It was therefore given until 7/1/2011 for CMS review and approval.
Implementation of both contracts has been delayed as a consequence of Legislative action (see section 3, Legislative Action) and, in the case of Basic Heath, the magnitude and complexity of changes ultimately required by CMS.

Basic Health:
Contract signatures are expected mid-July and will support implementation of key STC provisions that depend on the revised contract. These include cost-sharing changes for American Indians/Alaska Natives, enhanced enrollee notifications provisions, the Fair Hearings process, and adjusted rates that support these changes. Following extensive interaction with CMS over many months, the HCA reviewed the draft contract with managed care plans on 6/21/11. *Final* CMS approval is pending review of changes based on feedback from managed care plans; approval of the external quality review plan, attached as Appendix C, (developed with extensive CMS technical assistance); and program integrity-related requirements currently being developed for the Medicaid Healthy Options contract[2]. Based on discussions, a fully approved and complete BH contract would become effective no later than 10/1/11. Until then, the provisional revised contract would enable Transitional Bridge milestones to be implemented. Any further delay in contract revisions is of major concern to CMS, the State, and managed care plans.

Lessons Learned:
"Commercial" managed care contracts are very different from "standard Medicaid" contracts. In retrospect, given the magnitude of changes to meet CMS approval, it would have been more efficient to begin with the current Medicaid Healthy Options contract and revise it to fit BH program details. In addition, we frequently encountered terminology that meant something

[2] CMS has directed the State to update the Medicaid Healthy Options (HO) Contract to reflect requirements of the State Medicaid Manual, section 2807.6, Disclosure of Information on Business Transactions - State Plan Defined HMOs. In recent discussions to finalize major modifications to the BH contract for the waiver, we discovered that this amendment is also required in the BH contract. Given that the HO contract is the approved Medicaid standard, we requested approval to implement the change in the HO and BH contracts at the same time, to ensure that BH specifications are in accord with the HO provisions (still in development) and to allow MCOs to more efficiently implement the change for both programs simultaneously. HO changes are to be effective 10/1/11. BH changes will coincide.

very different to CMS than BH (e.g., disenrollment). This was not immediately apparent and required time-consuming (and often frustrating for all) discussions to understand. An initial confirmation of terminology may have helped. We believe that the expertise gained in developing the new BH contract will be very helpful as we transition to national health reform and potentially bring in new (commercially-oriented) managed care plans to serve Medicaid clients.

Medical Care Services:
The contract for Disability Lifeline is sole-source with CHPW (per STCs), and based on the Medicaid Healthy Options contract. A preliminary version was made available for CMS review; however it made little sense to conduct a full assessment until changes to support Legislative action were clarified. This was a moving target, with final legislation not enacted until 6/15/2011 and not fully effective until 11/1/11. Minor changes are needed in the current contract to avoid disruption in coverage for enrollees, effective 7/1/11, but the full impact of Legislative changes - new rates, changed program title, adoption of SPA benefit impacts, and the expansion of managed care services - cannot logistically be incorporated until October. CMS review of the BBA-compliant contract that incorporates these changes has just begun. We anticipate approval of the amended contract by 10/1/11 with amendments retro-active to 7/1/11.

Basic Health Social Security Interface:
An initial verification of citizenship for BH clients was successfully completed through a Social Security Administration (SSA) data match. However, the HCA was subsequently notified by SSA that additional contractual information would be needed prior to allowing any future automated citizenship data matching by BH. This complication has had little effect on the program and will be resolved in conjunction with the transfer of the Medicaid single state agency from the Department of Social and Health Services (DSHS) to the HCA, (see section 3, 2E2SHB 1738). HCA staff is currently reviewing additional data match contractual requirements.

Since enrollment into the Basic Health program was restricted by funding and to Transition Eligibles, citizenship verification for the few new applicants has been handled through a request for birth records from the applicants. The Medicaid agency has an established process for requesting birth records for clients who do not have their birth records. Basic Health applicants without birth verification are referred to the Medicaid agency for assistance through this standard process.

Termination from Basic Health of non-Transition Eligibles
The biggest operational challenge faced by the Basic Health program came from legislative action (see section 3, HB1544) which allowed *only* Transition Eligibles to be enrolled in Basic Health. This required mailings of thousands of letters within a very short timeframe, and prompted the redeployment of staff for weeks to manage the impact of appeals, follow-up information requests, retro-active coverage reinstatement and the transition of individuals determined eligible for Medicaid programs. In other operational respects, the implementation of the Transitional Bridge waiver was smooth and would have been much easier had there been time to simply implement the requirements of the waiver. Appendix D presents a timeline of the complex series of events set in motion by legislative action.

As legislation was being debated, Basic Health took proactive steps to minimize the potential impact on enrollees. In particular, information requests were distributed to gather SSN documentation and hopefully prevent a frenzied mass termination of individuals who did not appear to meet the Transition Eligible definition. Unfortunately the request for SSN information was followed so closely by legislation that fiscal constraints overtook operational planning. To support Legislative requirements enacted mid-

session, Basic Health had to initially terminate enrollment for 17,455 members, primarily because there was no record confirming their legal resident status and hence their status as Transition Eligible. (Legal resident/ citizenship determination had not been historically required for Basic Health eligibility, and individuals had not yet responded to an request for SSN information.) Assistance from the Medicaid agency became essential to establish standardized procedures and guide Basic Health through the determination of immigration status. The Citizenship and Alien Status Checklist, included as Appendix E, was created as an effective tool to process and document action taken for individuals who provided follow-up information. This was an extraordinarily labor-intensive process given the magnitude and quick-turnaround needed to complete status determinations and process reinstatements in the Basic Health program to sustain continuity of coverage for those eligible. At the same time, staff had to be trained to understand the impact of the new Basic Health requirements, to revise administrative procedures, and to develop new letters explaining the impact on members.

The following table summarizes the ultimate impact on Basic Health enrollment.

Action	Total Individuals Affected
SSN verification requests (2/2/2011)	17,455 (members)
Termination (2/18/2011)	16,989 (members)
Not a legal resident	12,441 (accounts)
Over age 64	595 (accounts)
Income higher than Transitional Bridge limit	838 (accounts)
Appeals received (4/11/2011)	7,398 (accounts)
Individuals reinstated retroactive to 3/1/11	4,188 (members)
Adjusted total individuals terminated from Basic Health	12,801 (members)

Lessons Learned:
Without an extensive collaborative cross-agency effort by HCA, Medicaid Purchasing Administration and DSHS staff, the response to Legislative action could not have been accomplished with as much painstaking concern for individuals affected. In addition, stakeholder organizations pitched in to help explain the impact of Legislative action and support those who were confused by implications to their coverage options. The importance and evidence of such a unified inter-agency effort is an encouraging model as Washington prepares for implementation of national health reform in 2014. In addition, keeping CMS apprised to offer timely technical assistance was essential.

Disability Lifeline Replacement, Wait List and Outreach
Effective 11/1/2011 cash assistance will end for MCS recipients who receive medical coverage funded under the Transitional Bridge. Major system modifications are now being developed to establish "standalone" eligibility for MCS based on the $339 income standard in effect on December 31, 2010, to sustain health coverage consistent with grandfathering provisions in the STCs. This will eliminate the need for the temporary workaround process but is a major operational challenge to put in place quickly. Three new programs will become effective, as shown on Appendix F, Disability Lifeline Replacement Overview.

- The **Aged, Blind or Disabled Assistance** program, provides cash assistance to individuals who are aged (65 years or older), blind (based on SSI blindness criteria), or who are determined likely to meet the SSI disability standard. To be eligible, applicants cannot already be receiving SSI.

- The **Pregnant Women Assistance** program for women who are not eligible for Temporary Assistance for Needy Families (TANF) for reasons other than failure to cooperate with a TANF program requirement.
- The **Medical Care Services and Essential Needs and Housing Support** program for individuals who are not disabled but who are unable to work for at least 90 days due to a physical or mental impairment. Consistent with the STCs for the Transitional Bridge, this is the same incapacity criteria as the current Disability Lifeline – Unemployable (DL-U) program. The law establishes income eligibility standards for the MCS program that are the same as those used to determine DL-U eligibility on December 31, 2010, also consistent with STCs. While clients will not be eligible for cash assistance under this new program, they will be referred to local entities for essential needs (e.g., personal hygiene items, bus passes) and housing support services. **With respect to the Transitional Bridge Demonstration, their status as Transition Eligibles will remain as defined by the STCs.** Individuals identified in the STCS as the Disability Lifeline and ADATSA Demonstration populations will continue to receive coverage through Medical Care Services. However, we will need to discuss technical corrections to the STCs to account for the program name changes.

Wait List

Criteria for coverage through the MCS program may no longer result in expenditures that exceed amounts appropriated in the State's operating budget. Appropriations are based on current DL and ADATSA caseload estimates so there is no immediate need to implement a wait list. However, management of enrollment, given the uncertainty of the state budget, may require imposition of a waiting list in the future. In the event this may be necessary, we are developing procedures for CMS review and approval, to meet current STC requirements and to determine necessary systems changes. We anticipate preliminary discussions with CMS will occur in early August, targeting governing policy and procedures for:

- Priority of enrollment from the wait list
- Disenrollment/terminations resulting from non-compliance for standard information requests
- Managing eligibility and incapacity review requirements for individuals on the wait list.

Outreach

Potential legislative changes to the Disability Lifeline program have been discussed regularly with community partners. Meetings attended this spring included the First Friday Forums held monthly in King County (currently almost half of the Disability Lifeline Medical Care Service caseload is located in King County), Consortium for Health Information and Access quarterly meetings in Pierce County and the Washington Coalition of Medicaid Outreach quarterly meetings held in various locations throughout the state. In June 2011, this meeting was held in Yakima County in Eastern Washington. All these community stakeholder meetings are attended by outreach agencies, state and county agencies, community health agencies, managed care organizations, rural health clinics, federally qualified health clinics, representatives from hospital associations and legal service advocates. We will continue to partner with stakeholders throughout the summer and early fall to help assist clients with upcoming program transitions.

5. Budget Neutrality

As context for the budget neutrality progress report, the following recaps details of the Transitional Bridge budget neutrality methodology. In addition it includes a budget neutrality tracking report that indicates caseloads, total expenditures and per-caps on a "rolling" basis. It also reviews the impact of the 2011 Legislative session on previous budget neutrality assumptions. Although this repeats information found elsewhere in the report, it is our intent that it be a "stand-alone" section on which we will need further discussion with CMS before submitting potential technical corrections/amendments to the Transitional Bridge Demonstration STCs. Need for this effort was discussed during the June 21, 2011 monitoring call.

Background:

Section 2001(a)(1) of the Affordable Care Act (ACA) established a new Medicaid eligibility group that all States participating in Medicaid must cover as of January 2014 and were able to begin to "phase-in" coverage for beginning April 1, 2010. Washington's Transitional Bridge demonstration employs this phase-in provision to provide subsidized coverage for a sub-set of adults (Transition Eligibles) who, prior to the demonstration, were covered under the state-funded Basic Health (BH) program (low income individuals up to 200 percent of the federal poverty level) or Medical Care Services (MCS) program (individuals who are unemployable for at least 90 days due to medical, mental health or chemical dependency incapacity.)[3] These individuals will be covered under a Medicaid State Plan amendment (SPA), effective January 2014. The Transitional Bridge allows Washington to use federal funds to cover individuals enrolled in these programs who meet the 133 percent countable income and Medicaid citizenship requirements.[4]

Budget Neutrality Model Overview:

Washington's Transitional Bridge demonstration's budget neutrality is based on a "per capita cost" methodology rather than the traditional 1115 demonstration five-year aggregate federal spending model.[5] It is based on CMS' 1115 demonstration policy, which considers individuals who would be otherwise eligible under a SPA as eligible under both the "with waiver" and "without waiver" budget neutrality calculations. It ensures that Washington does not supplant federal for state funds, that annual federal costs are not more than they would be under a SPA, and that savings from lower trends accrue to both the Federal and State governments. The model applies to the three-year life of the Transitional Bridge demonstration, which ends December 31, 2013.

Budget neutrality is based on having per-capita expenditures for the "with" waiver population that are less than the per-capita costs "without" the waiver. The Demonstration ensures that the federal and state governments incur costs that are less than "without" the waiver. Under this model they share in the financial cost for *caseload* changes in the BH and MCS programs, consistent with the existing Medicaid program's entitlement requirements.

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[3] See January 2011, Special Terms and Conditions, Section IV (page 7-8) for description of these eligibility groups.

[4] CMS policy set forth in the April 9, 2010, State Medicaid Director letter (SMDL#10-005) allows a State to "... use methods of determining incomes that are reasonable, consistent with the objectives of the Medicaid program, simple to administer and in the best interest of beneficiaries. " In consultation with CMS, Washington's demonstration adopted the treatment of income rules used in its Medicaid Family Medical program that allow for a 50 percent earned income disregard.

[5] See January 2011, Special Terms and Conditions, Section XI (page 24) for description of the methodology.

Washington agreed to base-year per-capita costs for Transition Eligibles in the BH and MCS programs below the costs "without" the waiver, and with a trend factor less than the President's budget for Medicaid. The STCs set the maximum trend factor at 5.3 percent, a full percentage point below the President's budget. This trend factor will be applied to the second (CY 2012) and third (CY 2013) years of the three-year demonstration. These provisions assure budget neutrality, assure that the State will not supplant federal funds for state funds, and hold the State liable for per-capita costs that exceed the 5.3 percent trend per-year.

Transitional Bridge budget neutrality calculations were initially submitted on July 7, 2010, as part of the State's formal demonstration proposal. As updated forecasts became available and Basic Health procurement negotiated, they were revised on July 23, 2010 and October 28, 2010, with final calculations submitted to CMS on December 7, 2010. Budget neutrality worksheets on which the STCs were developed are included as Appendix H, Original Budget Neutrality worksheets.

- Calculations were based on forecasted caseloads for the BH program, MCS coverage for Disability Lifeline, and MCS coverage for ADATSA.
- "Without waiver" per-capita costs were based on estimates prepared by Washington's consulting actuary, per the July 22, 2010, Milliman correspondence included in Appendix H.
- "With waiver" estimates were based on the Health Care Authority's forecasted per-capita expenditures for November 2010.

Basic Health						
	Without Waiver			With Waiver		
	Total	State	Federal	Total	State	Federal
CY 2011	$318.28	$159.14	$159.14	$184.00	$92.00	$92.00
CY 2012	$334.62	$167.31	$167.31	$203.44	$101.72	$101.72
CY 2013	$351.80	$175.90	$175.90	$214.22	$107.11	$107.11
Medical Care Services - DL						
	Without Waiver			With Waiver		
	Total	State	Federal	Total	State	Federal
CY 2011	$978.12	$489.06	$489.06	$713.96	$356.98	$356.98
CY 2012	$1,028.39	$514.20	$514.20	$751.80	$375.90	$375.90
CY 2013	$1,081.25	$540.63	$540.63	$791.64	$395.82	$395.82
Medical Care Services - ADATSA						
	Without Waiver			With Waiver		
	Total	State	Federal	Total	State	Federal
CY 2011	$536.31	$268.16	$268.16	$469.94	$234.97	$234.97
CY 2012	$642.57	$321.29	$321.29	$573.27	$286.64	$286.64
CY 2013	$675.60	$337.80	$337.80	$603.65	$301.83	$301.83

- Final budget neutrality per-capitas and annual trend factors included in the STCs, Section XI paragraph 54, are presented in the following table.

Demo Year	Basic Health Per Capita *	BH Trend	Disability Lifeline Per Capita	DL Trend	ADATSA Per Capita **	ADATSA Trend
1	$184.00	5.3%	$713.96	5.3%	$469.94	5.3%
2	$203.44	5.3%	$751.80	5.3%	$573.27	5.3%
3	$214.22	5.3%	$791.64	5.3%	$603.65	5.3%

Notes

* Additional programmatic changes required.

** Should the State not transition the ADATSA program into managed care in 2012 with the agreed to benefit changes for the Transitional Eligibles enrolled in that program, the PMPM for this population will revert to CY12 = $494.85 and CY13 = $521.08.

- Given that the "without" waiver coverage is for individuals who could have been covered under a SPA Section 1902(k)(2) expansion, administrative costs are considered to be the same for the "with" and "without" waiver budget neutrality calculations.[6]

Budget Neutrality Tracking Report:

The quarterly budget neutrality report, included as Appendix G, Proposed Budget Neutrality Tracking Worksheets, tracks estimates compared to actual expenditures. It includes:

Original December 2010 STC details:

- Caseloads for the BH, MCS-DL and MCS-ADATSA programs
- Per-capita costs for BH, MCS-DL and MCS-ADATSA programs
- Budget neutrality total expenditures for BH, MCS-DL and MCS-ADATSA programs

July 2011 estimates based on revised caseload forecasts:

- Revised caseloads for the BH, MCS-DL and MCS-ADATSA programs
- Original per-capita costs for MCS-DL and MCS-ADATSA programs
- Revised Basic Health per-capita costs (explanation follows)
- Budget neutrality total expenditures for BH, MCS-DL and MCS-ADATSA programs

Actual caseloads and expenditures (described further below):

- Actual caseloads for the BH, MCS-DL and MCS-ADATSA programs
- Actual per-capita costs for BH, MCS-DL and MCS-ADATSA programs
- Estimated total expenditures for MCS-DL and MCS-ADATSA programs

Caseload data:

The reporting of actual caseloads will differ across the three programs and the worksheets will be modified to reflect period caseload forecast updates where they are substantial.

- BH operates under full managed care in which enrollees must pay premiums prior to the coverage period. As a result, the State is able to provide accurate monthly enrollment one-month after the service month, with typically minor adjustments for the impact of subsequent transitions to Medicaid and potential retroactive eligibility.

[6] See January 2011, Special Terms and Conditions, Section X paragraph 42.

- Eligibility status is more complex for the MCS program because of systems processing and material retroactive eligibility transfers between MCS and Medicaid. As a result, the State will provide MCS enrollment in the fourth month after the service month.
- BH and MCS caseload data for a given service month are updated for further eligibility changes. The quarterly tracking report will incorporate these changes.

Expenditures:

Washington state expenditures are reported and tracked on an accrual (service month) basis, however there are differences across programs as a result of the delivery system complexities.

- BH operates under full managed care which normally allows per-capita data to be reported in the third month after the service month. Data currently available do not include supplemental payment to managed care plans for the AI/AN population exempt from cost sharing. This will take effect with the BH contract revision anticipated to be in place July 2011. (See section 4, Operational Challenges). Data included for BH in Appendix G incorporate "best estimates" for AI/AN payments and may therefore be revised (minimally) in the next quarterly report after adjusted payments have been made following signature of revised managed care contracts.
- MCS services are delivered through a combination of managed care and fee-for-service systems. While managed care payments are made prospectively, they are revised for changes in eligibility. Fee-for-service payments are subject to provider billings, in which providers have up to 12-months to bill for services for a given service month. Therefore, actual per-capita expenditures will begin to be reported six-months after the service month and will continue to be updated for at least 12-months.

Budget Neutrality Revisions:

Budget neutrality calculations and STC per-capitas were based on caseload and per-capita forecasts that preceded Washington's 2011 legislative session and its supplemental budget to closeout state fiscal year (SFY) 2011 and 2011-13 biennial budget for SFY 2012 and 2013.[7] As detailed in section 3, Legislative Action, several major changes were made to the BH and MCS programs. To provide perspective on their impact on budget neutrality, they are recapped here.

Basic Health:

- The 2011 early action supplemental budget (HB 3225) directed BH enrollment to be closed through the remainder of SFY 2011 with an assumption that subsidized BH enrollment would decline to 52,000 by June 2011 instead of increasing to 69,000 as previously budgeted.[8]
- The second 2011 supplemental budget (ESHB 1086) amended this assumption to require that BH enrollment be restricted further to only individuals who qualify for coverage under the Transitional Bridge waiver. The impact on enrollment, including appeals and reinstatements, is detailed in section 4, Operational Challenges. By mid April, close to 13,000 individuals were terminated from the program.
- The 2011-13 biennial budget (2ESHB 1087) continues to limit BH enrollment to only adults eligible under the Transitional Bridge demonstration. It also limits the caseload to an amount equal to a 1 percent attrition rate for SFY 2012 and SFY 2013, which is estimated to average approximately 37,000 enrollees per month for SFY 2012 and 33,000 per month during SFY 2013.

[7] Washington State's state fiscal year (SFY) is from July 1st through June 30th of the following year. For example, the SFY 2011 period is July 1, 2010 through June 30, 2011.

[8] The SFY 2010 supplemental budget implemented in May 5, 2010, assumed that Washington would be successful in obtaining the Transitional Bridge demonstration waiver with allowance for federal financial participation (FFP) to sustain the existing BH program and enrollment to 69,000 by June 2011.

- As described more fully in section 2, Enrollment, the Basic Health membership has changed considerably from the population on which our original Transitional Bridge application was based. Demographic shifts occurred in:
    - The age distribution - towards an older (and therefore more costly) membership
    - The income distribution – (slightly) towards a lower income membership, for whom subsidies are highest
    - The geographic distribution – membership is more concentrated in higher cost counties as a result of disproportionate disenrollment for relatively lower cost counties, King and Yakima in particular.

  Analysis of the impact of these demographic shifts on budget calculations and 2012 joint procurement activities is preliminary, but our real experience indicates that our original assumptions were for a very different base.

Medical Care Services – DL and ADATSA:

- Enabling legislation for the MCS program requires the program to be administered with the funds appropriated for the program, although the two supplemental budgets continued to fund MCS coverage for DL and ADATSA clients at their forecasted caseload and per-capita cost levels. As reviewed in section 4 Operational Challenges, it includes provisions to adopt a wait list and manage enrollment if enrollment is anticipated to result in expenditures exceeding appropriated funding for the fiscal year. However, it extends the requirements that DL clients enrolled in MCS be grandfathered into continued coverage if eligibility for DL changes to reduce enrollment.
- In enacting ESHB 2082 the Legislature eliminated the DL program effective October 31, 2011 but replaced it with three new assistance programs – Housing and Essential Needs Program, Pregnant Women Assistance Program, and the Aged, Blind, Disabled Assistance Program (see section 4, Operational Challenges and Appendix F for further details). Although the DL Transition Eligible population will no long receive grant assistance it will be eligible for Housing and Essential Needs Program, which provides funding through local housing assistance programs for housing support and limited funding to augment Supplemental Nutrition Assistance Program (SNAP). And, as a result of the Transitional Bridge, Transition Eligibles will continue to receive medical coverage through the Medical Care Services program with income /resource eligibility levels codified at the December 31, 2010 levels defined in the STCs.

Given policy changes from the 2011 legislative session, we need to discuss ramifications to STCs with CMS. We anticipate that changes may include revisions to:

- BH, MCS-DL and MCS-ADATSA caseload forecasts for the three-year demonstration period;
- BH base-year per-capita costs resulting from effectively redefining the program; and,
- MCS-DL base year per-capita to correct a computational error which mistakenly overstated a component of the per-capita calculation.

D. Evaluation Plan

While elements of an evaluation of the Transitional Bridge have been broached, this is the first evaluation plan outline submitted. We would like to hone it through discussion with CMS to maximize its usefulness for CMS, Washington, and other states during the transition to implementation of national health reform.

Background:

In relation to the first Transitional Bridge Demonstration goal of continuing coverage for low-income individuals enrolled in BH and MCS programs, we view the Transitional Bridge as a huge success. The hypothesis is that without the demonstration, Washington would no longer be able to offer subsidized coverage through BH or MCS. That is a widely shared view given that prior to approval of the Demonstration the Governor's *proposed* supplemental budgets for SFY 2009 and SFY 2010, and biennial budget for 2011-13, eliminated both programs.

Unlike typical section 1115 Demonstration waivers, the Transitional Bridge is a short-term three-year waiver in place only until December 31, 2013. After that date the existing BH and MCS demonstration programs will be terminated when the majority of their enrollees become eligible for the ACA Medicaid expansion. Remaining individuals will be eligible for either the Health Benefits Exchange or the ACA BH option if Washington elects to adopt it. The focus of the Transitional Bridge evaluation plan is therefore on our second Demonstration goal; using Transitional Bridge programs as a dynamic early-learning laboratory to:

- identify and resolve issues that many states may face in preparing to implement the ACA Medicaid expansion in 2014, and
- inform federal and state policy makers about program attributes that are consistent with ACA policy goals and provisions and could be considered for new and existing Medicaid eligible populations.

Context:

The evaluation plan has been developed in the context of Washington's partnership with the Centers for Medicare and Medicaid Innovations (CMMI), which is focused on modernizing the Medicaid program. In April 2011, Governor Gregoire submitted a proposal for flexibility, resources and technical assistance to support a variety of Health Innovations for Washington (HIW). The HIW proposal targets alignment of our Medicaid program with the ACA Health Benefits Exchange, expands partnerships with the DHHS to better manage Medicare/Medicaid dual eligibles, and includes payment reforms for both the state and private sectors to reduce the annual growth in medical expenditures to no more than 4.0% while improving health outcomes. It also includes efforts to redesign the Medicaid program for more seamless coverage transitions as low and moderate income individuals move between Medicaid, the Health Benefits Exchange and the ACA BH option. Alongside the HIW proposal, the 2011 Legislature enacted E2SSB 5596, which directs the HCA to work with CMMI/CMS on approaches to modernize Medicaid. In particular, the E2SSB 5596 and HIW proposals envision premiums and targeted point-of-service cost sharing for Medicaid; and a core benefit for Medicaid based on the ACA essential health benefits with supplemental coverage for children, persons with disabilities, and elderly persons.

Evaluation Focus:

The Transitional Bridge evaluation focuses on areas of analysis that will inform discussions on cost sharing and essential benefits. In addition, it provides an opportunity for a qualitative review of challenges in linking Medicaid and non-Medicaid administrative systems to support coverage for low income individuals under national health reform. Some of the operational challenges are reflected in section 4. These would be expanded through a more thorough review.

Effect of Cost-Sharing on Service Utilization and Health Outcomes:
A number of States have implemented point-of-service cost-sharing in their Medicaid benefit designs to incent more appropriate use of health services. Congress sought to provide States with additional flexibility to adopt premiums as well as point-of-service cost-sharing through the Deficit Reduction Act of 2005 (DRA) section 6041, 6042 and 6043 provisions. While yet to be fully defined, the ACA provides States the ability to impose these forms of cost sharing on the Medicaid expansion new eligibility group, consistent with DRA provisions for current Medicaid eligibility groups.

The Transitional Bridge has historically demonstrated cost-sharing beyond the DRA scope, i.e., level of cost-sharing and enforceability. The BH program has employed cost-sharing since its inception in 1988 and low-income individuals and families have sought enrollment in the program far beyond what the State has been able to finance. Moreover, Washington (and other states') policy makers, are very interested in adopting cost-sharing beyond the restrictive limits allowed in the DRA. For example, in addition to the E2SSB 5596 directives, the 2011 Legislature adopted a 2011-13 biennial budget for the Medicaid program that assumes savings from prescription drug cost-sharing (per the BH model). The Legislature directed the HCA to seek an 1115 demonstration waiver to adopt this cost-sharing design by June 30, 2012.

To inform the discussion around cost-sharing options, we propose a Transitional Bridge evaluation that would test the impact of BH point-of-service cost-sharing on:

(a) utilization of specified services and;
(b) health outcomes (related to use of primary care, specialty screening, and treatment for preventable care.)

Among the measures to be considered for inclusion in the evaluation are:

- Total hospital admissions, AHRQ preventive quality indicator hospital admissions, and readmissions
- Total emergency department (ED) visits, avoidable ED visits using New York University's algorithm
- Generic prescription fill rates, medication possession ratios
- Asthma control indicators, including use of rescue inhalers and asthma associated hospitalizations
- Diabetes control indicators, including A1c testing, eye exams and foot exams; continuity of care index, measuring degree to which client seeks primary care from single provider
- Mortality and survival rates.

The evaluation proposes to triangulate results from three complementary analytic designs:

- **Two Group Comparison Analysis:** Historically, people who were income-eligible for Medicaid signed up for BH instead for a host of reasons (e.g., stigma, lack of knowledge), creating a natural experimental design to compare BH clients with cost-sharing versus similar Medicaid

clients without cost-sharing. Starting with the eligible low-income BH group, a propensity score matched sample will be drawn from the Medicaid population. Matching variables will include income, eligibility period, age, gender, geographic location, chronic disease prevalence, and other factors unrelated to utilization. Descriptive analysis will be supplemented with a 2-sample t-test of means.

- **Interrupted Time Series Comparison Analysis**: As a requirement of the Transitional Bridge demonstration, BH enrollees who are eligible for "regular" Medicaid coverage must be disenrolled from BH and enrolled in Medicaid. To model the transition effect, we will go back in time if necessary to find individuals who have already transitioned from BH to Medicaid, preferably with at least one year of coverage in each program. They will be followed over time, before and after their Medicaid transition, to see if their service utilization and health outcomes change. Two additional groups will be created and tracked - a matched sample of individuals who were on BH the entire period, and a matched sample of those who were on Medicaid the entire period, to control for historical trends within the BH and Medicaid programs. Analysis techniques will include multiple and spline regression.

- **Client Survey**: A pretest/posttest telephone survey will be conducted using standardized questions for clients who will be moved from BH to Medicaid, to capture their perspective on how cost-sharing influenced their service utilization.

Actuarial Comparison of Essential Health Benefits, Medicaid and Basic Health Coverage:
The ACA establishes an essential health benefits design to be offered in the Health Benefits Exchange. It also amends Medicaid statute to require that benefits for the new eligibility group match benchmark or benchmark-equivalent coverage[9] that meets the minimum benefit and cost-sharing standards of a basic plan offered through the Exchange. In an effort to modernize its Medicaid program (as described above), Washington will be seeking necessary waivers to adopt the essential health benefits for both the Medicaid expansion new eligibility group and current Medicaid eligibility groups. As described above, the state would provide supplemental benefit coverage for children the same as for existing coverage unless the essential benefits coverage is more comprehensive. It would also provide supplemental benefit coverage for persons with disabilities and elderly persons, including long-term care services currently offered to these eligibility groups.

As a component of the Transitional Bridge evaluation, we propose to conduct an actuarial comparison of the value of current Medicaid medical and behavioral health coverage for adults, existing BH coverage under the demonstration, and the Essential Health Benefits design, once details are available. The analysis would specifically include comparisons based on the existing Medicaid CN Family Medical (TANF related), CN Blind/Disabled, and CN Elderly populations, with a separate comparison for Medicaid and CHIP children. Analysis would include actuarial value with the adoption of point-of-service cost sharing allowed under the Health Benefit Exchange's platinum coverage model.

[9] The concept of "benchmark" or "benchmark equivalent" coverage was introduced in the DRA, Section 1937.

Appendices:

Appendix A: American Indian Health Commission Workgroup

SUMMARY OF CURRENT DISCUSSION

Introduction

Special Terms and Conditions (STCs) for the Transitional Bridge Demonstration require that individuals enrolled in the Basic Health program "who have been determined to be American Indians/Alaska Natives" be exempt from cost sharing. This is consistent with requirements of the Patient Protection and Affordable Care Act (ACA).

The American Indian Health Commission (AIHC) is facilitating a work group to support Washington state's efforts to implement this requirement. Initial discussions focus on operationalizing the definition of American Indian/Alaska Native (AI/AN) so that individuals to whom the cost sharing exemption applies can be clearly identified and tracked. The following documents the workgroup's progress thus far in:

a. clarifying the federal definition of an American Indian/Alaska Native Indian, and
b. determining the array of official documents that would support an individual's claim to be an Indian.

Implementation of the work group's findings will require approval of the Centers for Medicaid and Medicare Services (CMS) consistent with the STCs.

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a. **Definition of American Indian/Alaska Native *Indian***

STCs (i.e., page 12 footnote) use a definition of "Indian" consistent with Section 5006 of the American Recovery and Reinvestment Act (ARRA) and with the ACA. This definition is presented in the following box, with references to current law bolded and relevant excerpts shaded in grey in the text that follows for 42 CFR 136.12, and 25 USC 1603(c), 1603(f), 1679(b).

> Indian means any individual defined at **25 USC 1603(c), 1603(f), or 1679(b)**, or who has been determined eligible as an Indian, pursuant to **42 CFR 136.12**. This means the individual:
> (1) Is a member of a Federally recognized Indian tribe;
> (2) resides in an urban center and meets one or more of the four criteria:
> (a) Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the
> State in which they reside, or who is a descendant, in the first or second degree, of any such member;
> (b) is an Eskimo or Aleut or other Alaska Native;
> (c) is considered by the Secretary of the Interior to be an Indian for any purpose; or
> (d) is determined to be an Indian under regulations promulgated by the
> Secretary;
> (3) is considered by the Secretary of the Interior to be an Indian for any purpose; or
> (4) is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

42 CFR 136.12 - Persons to whom services will be provided.

(a) *In general.* Services will be made available, as medically indicated, to persons of Indian descent belonging to the Indian community served by the local facilities and program. Services will also be

made available, as medically indicated, to a non-Indian woman pregnant with an eligible Indian's child but only during the period of her pregnancy through postpartum (generally about 6 weeks after delivery). In cases where the woman is not married to the eligible Indian under applicable state or tribal law, paternity must be acknowledged in writing by the Indian or determined by order of a court of competent jurisdiction. The Service will also provide medically indicated services to non-Indian members of an eligible Indian's household if the medical officer in charge determines that this is necessary to control acute infectious disease or a public health hazard.
(2) Generally, an individual may be regarded as within the scope of the Indian health and medical service program if he/she is regarded as an Indian by the community in which he/she lives as evidenced by such factors as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation in tribal affairs, or other relevant factors in keeping with general Bureau of Indian Affairs practices in the jurisdiction.
(b) *Doubtful cases.* (1) In case of doubt as to whether an individual applying for care is within the scope of the program, the medical officer in charge shall obtain from the appropriate BIA officials in the jurisdiction information that is pertinent to his/her determination of the individual's continuing relationship to the Indian population group served by the local program.
(2) If the applicant's condition is such that immediate care and treatment are necessary, services shall be provided pending identification as an Indian beneficiary.
(c) *Priorities when funds, facilities, or personnel are insufficient to provide the indicated volume of services.* Priorities for care and treatment, as among individuals who are within the scope of the program, will be determined on the basis of relative medical need and access to other arrangements for obtaining the necessary care.

Sec. 1603. Definitions

For purposes of this chapter--

(a) ``Secretary'', unless otherwise designated, means the Secretary of Health and Human Services.

(b) ``Service'' means the Indian Health Service.

(c) ``Indians'' or ``Indian'', unless otherwise designated, means any person who is a member of an Indian tribe, as defined in subsection (d) of this section, except that, for the purpose of sections 1612 and 1613 of this title, such terms shall mean any individual who (1), irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member, or (2) is an Eskimo or Aleut or other Alaska Native, or (3) is considered by the Secretary of the Interior to be an Indian for any purpose, or (4) is determined to be an Indian under regulations promulgated by the Secretary.

(d) ``Indian tribe'' means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 U.S.C. 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(e) ``Tribal organization'' means the elected governing body of any Indian tribe or any legally established organization of Indians which is controlled by one or more such bodies or by a board of directors elected or selected by one or more such bodies (or elected by the Indian population to be served by such organization) and which includes the maximum participation of Indians in all phases of its activities.

(f) ``Urban Indian'' means any individual who resides in an urban center, as defined in subsection (g) of this section, and who meets one or more of the four criteria in subsection (c)(1) through (4) of this section.

(g) ``Urban center'' means any community which has a sufficient urban Indian population with unmet health needs to warrant assistance under subchapter IV of this chapter, as determined by the Secretary.

(h) ``Urban Indian organization'' means a nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 1653(a) of this title.

(i) ``Area office'' means an administrative entity including a program office, within the Indian Health Service through which services and funds are provided to the service units within a defined geographic area.

(j) ``Service unit'' means--

(1) an administrative entity within the Indian Health Service,

or

(2) a tribe or tribal organization operating health care programs or facilities with funds from the Service under the Indian Self-Determination Act [25 U.S.C. 450f et seq.], through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.

(k) ``Health promotion'' includes--

(1) cessation of tobacco smoking,
(2) reduction in the misuse of alcohol and drugs,
(3) improvement of nutrition,
(4) improvement in physical fitness,
(5) family planning,
(6) control of stress, and
(7) pregnancy and infant care (including prevention of fetal alcohol syndrome).

(l) ``Disease prevention'' includes--

(1) immunizations,
(2) control of high blood pressure,
(3) control of sexually transmittable diseases,
(4) prevention and control of diabetes,
(5) control of toxic agents,
(6) occupational safety and health,
(7) accident prevention,
(8) fluoridation of water, and
(9) control of infectious agents.

(m) ``Service area'' means the geographical area served by each area office.

(n) ``Health profession'' means allopathic medicine, family medicine, internal medicine, pediatrics, geriatric medicine, obstetrics and gynecology, podiatric medicine, nursing, public health nursing, dentistry, psychiatry, osteopathy, optometry, pharmacy, psychology, public health, social work, marriage and family therapy, chiropractic medicine, environmental health and engineering, an allied health profession, or any other health profession.

(o) ``Substance abuse'' includes inhalant abuse.

(p) ``FAE'' means fetal alcohol effect.

(q) ``FAS'' means fetal alcohol syndrome.

Sec. 1679. Eligibility of California Indians

(a) Report to Congress

(1) In order to provide the Congress with sufficient data to determine which Indians in the State of California should be eligible for health services provided by the Service, the Secretary shall, by no later than the date that is 3 years after November 23, 1988, prepare and submit to the Congress a report which sets forth--

(A) a determination by the Secretary of the number of Indians described in subsection (b)(2) of this section, and the number of Indians described in subsection (b)(3) of this section, who are not members of an Indian tribe recognized by the Federal Government,

(B) the geographic location of such Indians,

(C) the Indian tribes of which such Indians are members,

(D) an assessment of the current health status, and health care needs, of such Indians, and

(E) an assessment of the actual availability and accessibility of alternative resources for the health care of such Indians that such Indians would have to rely on if the Service did not provide for the health care of such Indians.

(2) The report required under paragraph (1) shall be prepared by the Secretary--

(A) in consultation with the Secretary of the Interior, and

(B) with the assistance of the tribal health programs providing services to the Indians described in paragraph (2) or (3) of subsection (b) of this section who are not members of any Indian tribe recognized by the Federal Government.

(b) Eligible Indians

Until such time as any subsequent law may otherwise provide, the following California Indians shall be eligible for health services provided by the Service:

(1) Any member of a federally recognized Indian tribe.

(2) Any descendant of an Indian who was residing in California on June 1, 1852, but only if such descendant--

(A) is living in California,

(B) is a member of the Indian community served by a local program of the Service, and

(C) is regarded as an Indian by the community in which such descendant lives.

(3) Any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California.

(4) Any Indian in California who is listed on the plans for distribution of the assets of California rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

(c) Scope of eligibility

Nothing in this section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

b. Options for Documenting American Indian/Alaska Native *Indian* Status

To support an application for coverage as an *Indian,* for which an exemption from cost sharing will apply, an applicant must have documentation to confirm Tribal:

a. Membership,
b. Descendancy, or
c. Affiliation.

The following table provides 3 tiers of documents, with tiers representing increasing complexity of documentation requirements. Tier I documents are likely to be the most readily available; tier III may require the assistance of Tribal organizations to locate details.

DOCUMENTS THAT CONFIRM INDIAN STATUS		
TIER I	**TIER II**	**TIER III**
1. Tribal Membership Card with picture from a federally recognized tribe. state recognized tribe or the Bureau of Indian Affairs (BIA) 2. Tribal Sponsorship Agreement with the Health Care Authority for participation in the Basic Health program*	1. Current state driver's license with individual's picture, or a state identity card with individual's picture; AND a. A US American Indian/Alaska Native tribal membership card or tribal enrollment letter, without picture OR b. A certificate of tribal membership / affiliation, OR c. A document issued by the Bureau of Indian Affairs, such as Certificate of Indian Blood, OR d. A document issued by the Indian Health Service (IHS), a Tribal health program or an Urban Indian Program, attesting to an individual's eligibility (as an AI/AN) to receive health services at the IHS or Tribal health facility. ** 2. Indian and Northern Affairs Canada (INAC) Card; AND Documentation of 50% Native blood, such as: a. A Certificate of Indian blood issued by the Bureau of Indian Affairs OR b. A document issued by a federal or state recognized tribe verifying 50% Native blood***	1. Current state driver's license with individual's picture, or a state identity card with individual's picture; AND a. Documentation showing native descent, such as a birth certificate or relative tribal ID cards; OR b. A document issued by the Bureau of Indian Affairs, such as Certificate of Indian Blood. 2. Current state driver's license or state identity card for a non-native mother carrying the child of an eligible native****; AND a. Proof of marriage to an eligible native father who must also provide tier I,II, or III documentation that confirms his AI/AN status; OR b. In cases where the mother is not married to the eligible native father - proof of paternity (in writing), from the father or by order of a court, including a tribal court. The father must also provide tier I, II, or III documentation that confirms his AI/AN status (unless there is a tribal court order).

* Tribal Sponsors are expected to obtain and maintain complete documentation of eligible native status as part of their sponsorship agreement with the Health Care Authority.

** In the state of Washington there are currently 2 Urban Indian Health Centers, 3 Indian Health Service Clinics, and 34 Tribal Health Programs.

*** May be Canadian citizens but remain eligible for Basic Health and zero cost sharing if 50% native blood. The right of American Indians to freely cross the Canadian Border is based on the Jay Treaty signed by the US and Great Britain in 1794. In 1952, the Immigration and Naturalization Act limited the rights of Indians born in Canada to those with at least 50% native blood.

****Non-Native women pregnant with the child of an eligible Native remain eligible for zero cost sharing only during pregnancy and up to six weeks post-partum..

Appendix B: Enrollment Charts

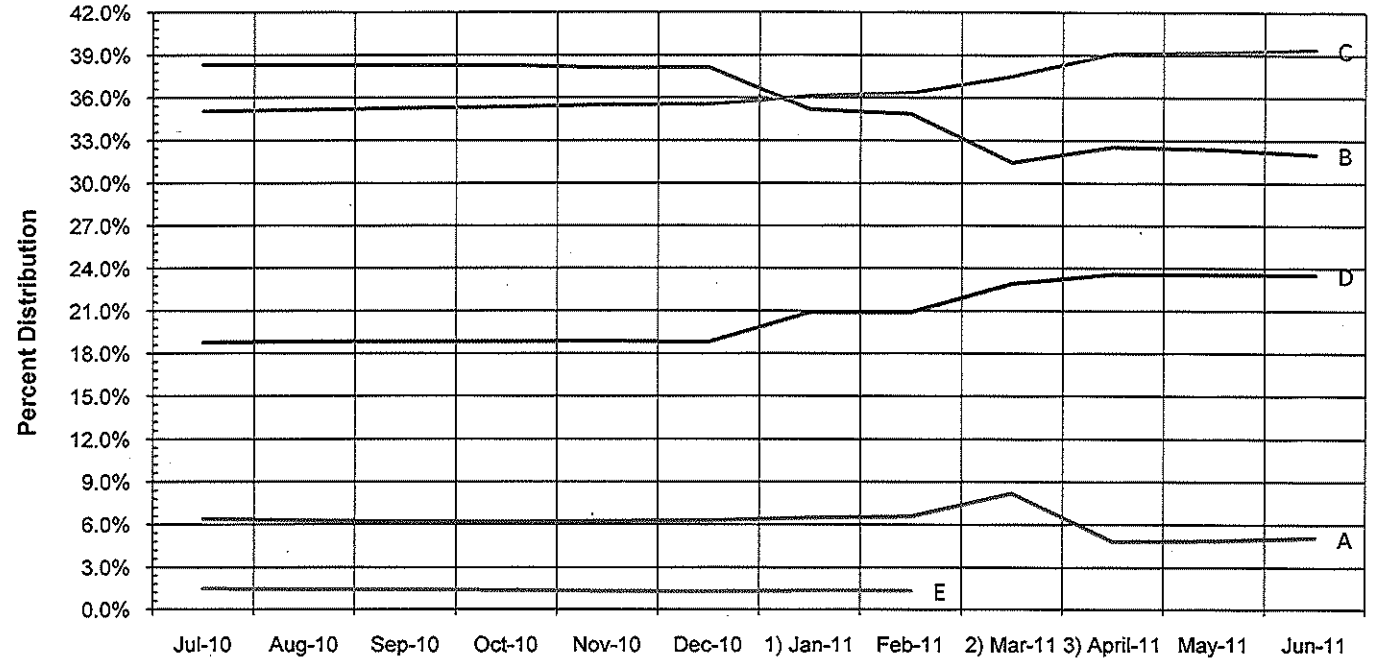
Basic Health Subsidized - July 2010 through June 2011

Age Band Distribution - Percent of Total Enrollment

Age Band Current:

A - Age 19 - 25
B - Age 19 - 39
C - Age 40 - 54
D - Age 55 - 64

1) January 2011 Enrollment - National Health Care Reform dependent Age Band "A" increases from up to Age 22 to age 25. Annual age rate adjustment.
2) March 2011Enrollment - initial 1115 Medicaid Demonstration Waiver and Legislative activity: Age Band "E" no longer eligible; Countable income up to 133% FPL of Non-Foster Parent members; Legal residency required.
3) April 2011 Enrollment - Apple Health for Kids transfer. Age 18 and under no longer eligible for Age Bands "A" and "B".



Age Band up to Dec-10:

A - Age 0 - 22
B - Age 0 - 39
C - Age 40 - 54
D - Age 55 - 64
E - Age 65 +